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HEALTH POLICY IN CANADA

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HEALTH POLICY IN CANADA*

ISSUE DEFINITION

Canadian health policy has led to one of the best health services systems in the world. The demands for these health services are, however, growing at the same time as economic resources are diminishing. Health policy initiatives have achieved the 1964 Royal Commission on Health Services goal of access to medical care for all Canadians. The current challenge is to provide access for all Canadians to a clear state of health and to do this within the constraints imposed by a changing social, economic and political climate.

This paper addresses some of the forces involved in the process of creating health policy or policies for health, focusing on the federal government's responsibilities and some of the intricacies of federal-provincial cooperation. It outlines the way health care is currently financed and what this means in terms of organization, as well as highlighting some of the challenges as new policy goals are identified.

BACKGROUND AND ANALYSIS

This focus on the concept of health, rather than illness, has occupied considerable space in policy discussions over the past two decades. At the federal level, the Lalonde Report in 1974 established that the setting of health goals or strategies was essential and emphasized that health care organization, particularly the provision of services, was only one of several elements affecting health. This view was reiterated in the Epp Report in 1986, which stressed that all public policy sectors - income security, employment, education, housing, agriculture and others have a

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bearing on health. In 1994, a federal, provincial and territorial advisory committee identified five categories of factors that determine the health of Canadians: social and economic environment; physical environment; personal health practices; individual capacity and coping skills; and health services. It argued that these could provide the basis for developing broad population health strategies for improving the health status of the Canadian population.

In spite of these attempts to refocus public policy, the belief that improvements in health can be attributed to services provided by doctors and hospitals is still dominant. While health is generally defined as a state of complete physical, mental and social well-being, rather than merely the absence of disease, the strong relationship between health and social and economic conditions is only gradually becoming part of the broader public knowledge.

A. Government Responsibility for Health

At Confederation, the *Constitution Act, 1867* made few specific references to health responsibilities. The federal government was allocated jurisdiction over marine hospitals and quarantine while the provinces were to establish, maintain and manage hospitals, asylums, charities and charitable institutions. From 1867 to 1919, the Department of Agriculture covered any related health concerns.

In the 74 years between the establishment of the first federal health department and the emergence of a reconstituted health department in 1993, federal government responsibility grew to include health services for Indian and Inuit people, residents of the Yukon, federal government employees, immigrants and civil aviation personnel. It also included investigations into public health, the regulation of food and drugs, inspection of medical devices, the administration of health care insurance, and general information services related to health conditions and practices.

Over time, the provinces, by virtue of their jurisdiction over matters of a local or private nature, also assumed an increasing role in health matters. The advances made in public health in the last decade of the nineteenth century were attributed to a combined effort by health professionals, the voluntary community, and the departments of health established at the municipal and provincial levels in the 1880s.

The provinces oversee the licensing of physicians, nurses and other health professionals and determine the standards for licensing all hospitals. In addition, departments of health administer provincial medical insurance plans and finance health care facilities and the delivery of certain public health services.

In the past decade, every province has established a Royal Commission or other major inquiry into its health care system. All concluded that the fundamental principles underlying the Canadian system of funding health care and enshrined in the *Canada Health Act* - universality, comprehensiveness, portability, accessibility and public funding from taxation - were sound. In addition, they argued that current levels of health care resources are sufficient.

The conclusions did, however, point to major inadequacies in the management of these resources. The provincial reports pressed for a definition of health that would address issues other than medical care, such as education, housing, employment and the environment. They advocated a shift from institution-based care to community-based care with more opportunity for individuals to participate in health decisions with service providers. The reports argued for better regional management of services and of human resources, including physicians, expressed concern about the efficiency and effectiveness of the current system, and called for evaluations of medical practice and delivery systems.

Cooperation and coordination with provincial and territorial governments being essential, various mechanisms ensure that federal, provincial and territorial health officials meet to discuss issues and solutions. The Conference of Ministers of Health and the Conference of Deputy Ministers of Health are two such mechanisms with important implications for national health policy. The meetings of the Ministers of Health generally take place less regularly than those of the Deputy Ministers, who meet twice annually and currently have three main committees focusing on population health, health services and health human resources.

B. Financing Health

Federal-provincial relations and fiscal arrangements have always had a significant impact on health policy. The federal government was constitutionally given the power to generate

financial resources through taxation and borrowing and to spend such money on any activity, provided that the legislation authorizing the expenditure did not infringe on provincial powers.

This power led to the National Health Grants Program of 1948, seen by many as the first stage in the development of a comprehensive health insurance plan for all Canada. The grants offering financial support for planning and organization, public health, and hospital construction provided a welcome source of new funds for the provincial health departments. For both levels of government, they gave an opportunity to discuss annual expenditures and to compare problems and solutions. The grants were followed by other cost-sharing measures under the federal *Hospital Insurance and Diagnostic Services Act, 1957* and the *Medical Care Act, 1966*. These statutes, which specified that all provinces must meet certain terms and conditions, were considered to be the second stage of a national health insurance system.

Although all provinces had joined the federal plan by 1971, problems were perceived by both parties to the agreement. The federal government became concerned about its lack of control over expenditures, while some provinces found the restriction to hospital and medical care expenses too limiting at a time when a shift to community-based care and preventive programs offered by non-medical personnel was beginning to be viewed as more effective.

After much discussion between the federal and provincial governments, the previous funding conditions were replaced by the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977*. Each province was given "block-funding," a set amount of federal money based on its population and paid partly in cash and partly in tax points. These per capita EPF payments by the federal government were to be spent on health but did not require that the provinces make equivalent matching expenditures.

As early as 1979, the federal government expressed concern that federal funds allocated for health were being diverted by the provinces into non-health activities such as road building. Two inquiries, the 1979 Health Services Review and a 1980 House of Commons Task Force established to investigate issues related to federal-provincial funding arrangements, failed to find evidence of such practices. However, the presence in several provinces of user fees for certain services and of extra-billing by physicians led to recommendations on measures to prevent the development of a two-tier system of health care.

In 1984, the *Canada Health Act* was passed to "establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law." The provisions of the two previous insurance Acts were consolidated in the new law, which reaffirmed the principles - public administration, comprehensiveness, universality, portability, and accessibility - underlying the national programs. Specific conditions were set for provincial receipt of the full federal contribution. The provinces were given three years to end extra-billing and user charges if they wanted to recover withheld funds. After significant federal-provincial debate, all provinces complied with the *Canada Health Act* by 1 April 1987.

After 1977, the federal government made several unilateral modifications to the formula for the federal contribution that limited the overall amount available to the provinces. This action led some observers to conclude that the federal government would be unable to enforce the standards of the *Canada Health Act* as cash transfers to the provinces ceased, since it would not be able to withhold cash transfers from any province that breached the criteria specified in the Act. Provinces claimed that financial pressures made it very difficult for them to maintain the current level of services.

In 1995, the government gave notice that a new block grant to the provinces, to be called the Canada Health and Social Transfer, would begin in 1996-97. It merged the Established Programs Financing (EPF) and Canada Assistance Plan (CAP). The Finance Minister noted that the new transfer would not be totally unconditional and that the *Canada Health Act* would still be enforced. Critics have argued that the CHST continues the policy of restricting expenditures without providing new approaches for increased efficiency in maintaining or delivering health.

C. Organizing Health

In reality, Canadian health policy has been predominantly health care policy, with the focus on the treatment of diseases and injuries rather than on prevention. In Canada, where a universal public insurance system called medicare provides for medical and hospital services, the two areas of financing and of organizing health services have been closely interwoven. The

acceptance of medicare as a way of financing existing services has also implied acceptance of existing ways of organizing those services.

Canada provides universal health insurance coverage for its population through health insurance programs jointly financed by federal and provincial or territorial authorities, which design their own programs following national standards codified in the *Canada Health Act*. Provincial and territorial health insurance plans currently cover services offered mostly in the offices of physicians paid on a fee-for-service basis and in hospitals, largely run by private, non-profit boards and operating on global budgets drawn mainly from funds provided by provincial governments.

Across the country, more than half of the funding for health care expenditures is allocated to hospitals and physicians. Physicians have a major influence on all the costs of the health care system, including the number and type of procedures and interventions offered in both private offices and publicly funded hospitals. As much as 78% of the increase in health care costs in industrialized countries over the past 25 years has been attributed to the number of physicians and the extent and level of services they provide for each patient.

In Canada, the 1964 recommendation that medical school capacity be expanded led to an increase in physicians that transmitted directly into increases in the use and cost of both physician and hospital services. During the decade between 1979 and 1989, the physician-to-patient ratio went from 1 physician for every 656 Canadians to 1 physician for every 515 Canadians. Many observers are concerned that the "surplus" of physicians, especially in urban areas, will contribute to increased health care costs. At the September 1993 meeting, federal, provincial and territorial ministers agreed to establish and coordinate provincial initiatives to ensure an adequate supply and distribution of physicians to meet the health needs of Canadians.

Beyond the traditional health care organization involving hospitals and physicians is a range of other services and programs that contribute to health. Other health professionals, such as nurses, chiropractors, midwives and physiotherapists, and other institutional arrangements, such as community-based clinics, can deliver health services, perhaps more effectively and less expensively than the existing methods. Changing the widely held belief that medical care and hospital care are the major determinants of long-term improvements in health status will be a major challenge for the next decades.

D. Groups with Particular Needs

The *Canada Health Act* is intended to guarantee equal access to health services and health care; however, it does not guarantee access to the conditions that lead to good health, which, as numerous studies have pointed out, can include a person's economic status, age, gender, occupation and ethnicity. In Canada, geographic location in urban or rural areas is another influence. Addressing the health concerns and particular needs of different groups requires varied initiatives.

Economic status is a primary factor affecting mortality, morbidity, and disability. Thus, low-income groups die younger, experience fewer years free of disability, and are more likely to have conditions such as high blood pressure, chronic respiratory disease and mental health disorders. In addition, they are less likely to use health services and to practise health protective behaviour. Within the low-income category, groups identified as having a higher chance of experiencing poor health include older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants.

Age is also a factor in health; young people and the elderly have distinct health concerns. For young people of both sexes, who in the teen and early adult years face major biological and social changes, motor vehicle accidents are the largest single cause of death, followed by suicide, cancer and homicide. For older Canadians, age-related chronic conditions include heart disease, arthritis, hypertension. Forms of senile dementia, including Alzheimer's Disease, are a growing concern.

Gender brings another dimension to health policy considerations. Women live longer than men but suffer more from chronic poor health. Women use health services more than men, at least partly because of their childbearing role. Heart disease is the number one killer of women, yet heart treatments have been developed particularly for men and evidence suggests that women receive less medical care. Young women face particular problems, such as eating disorders and unintended pregnancies.

The nature of jobs and the workplace affects the health of workers. Men and women often face daily exposure to hazards such as chemicals, noise, radiation, infectious agents, and psychosocial stress that lead to poor health. While injuries and deaths are acknowledged to be

related to industrial jobs, the fact that long-term illnesses often result from exposure to hazards in non-industrial settings is taking longer to be accepted.

Services responsive to the linguistic and cultural differences of aboriginal people, immigrants and cultural minorities are often unavailable. Adverse social and economic conditions among native people contribute to the high suicide rate of the young and the high rate of diabetes and tuberculosis among older people.

E. Health Policy Challenges

1. The Movement toward Health

Traditionally, the focus of medicine and the allocation of health care resources has been on how to control, cure, or alleviate disease. The lack of significant improvements in the overall health status of Canadians, despite increasing resource allocation to medical services and hospitals, led to some rethinking of health policy. It was recognized that the major causes of illness had changed from infectious to chronic agents and that environmental conditions and personal behaviour were major determinants of health. As studies indicated that the health status of Canadians was strongly linked to such factors as education, employment and income levels, emphasis shifted to the maintenance and enhancement of health.

Health promotion and population health are two concepts underlying policies for health. The World Health Organization defines health promotion as "the process of enabling people to increase control over, and to improve, their health." This led health departments to focus on issues such as nutrition, smoking, alcohol use, drug use, safety and mental health, and to identify several groups requiring priority attention, including children and youth, women, the elderly, the handicapped and chronically ill, non-status Indians and Métis and the poor. Over the next decade, the health promotion effort aimed at reducing inequities, increasing prevention and enhancing people's capacity to cope.

The population health approach emphasizes that any strategy to influence the health status of a population must address a broad range of health determinants, from the social and economic environment to health services. This differs in several ways from the traditional medical and health care approach. First, it addresses the entire range of factors that determine health, while

the traditional focus has been primarily on risks and clinical factors related to particular diseases. Second, population health strategies are designed to affect the entire population while health care deals with one individual at a time, usually one who already has a health problem or is at significant risk of developing one.

All levels of governments have recognized the need to refocus their health policies. Various federal initiatives have included the national Health Promotion Survey carried out in 1985 and 1990. Canada's Drug Strategy, which is scheduled to end in 1997, emphasizes community action involving private corporations, police, communities, families and individuals and coordinates efforts to reduce harm caused by alcohol and other drugs. Under the Child Development Initiative (formerly Brighter Futures), activities focus on child health goals, healthy babies, breast-feeding, childhood safety, strengthening families, and community action. This last component aims to support communities in meeting the needs of at-risk children from birth up to six years of age. It is based on evidence that every dollar invested in the health of a young child can result in a seven-dollar saving down the road in reduced social expenses, including lower health, welfare, and criminal justice costs.

Provincial and territorial governments have also recognized that health cannot be achieved solely by the provision of medical services. In extensive reviews of their health systems, provinces have called for a broader definition of health involving the collaboration of several policy sectors and a shift from curing illness to promoting health. In 1987, the Ontario Health Review Panel called for a vision of health for individuals that included a safe non-violent environment, adequate income, housing, food, and education, and a valued role in family, work, and the community. The Northwest Territories in 1995 developed a Community Wellness Strategy that called for a strengthening of community and family life, personal dignity, well-being, culture and tradition, together with integrated services and zero tolerance for violence.

2. Cost Effectiveness

The current economic climate of large government deficits and reduced transfer payments to the provinces, in combination with increasing health care costs, has forced a new look at how decisions are made in the current health care system. Most observers believe that these decisions should be based on evidence that meets certain standards of reliability and validity. It

must then be determined whether particular current procedures, practices or programs are effective or efficient.

Access to good health data is essential in order to document both the level of resources consumed by health care and the benefits thereby produced. At present, the collection of data necessary to maintain and improve health across the country is not coordinated or coherent. Definitions and concepts are not consistent among provinces, and systems for collecting and synthesizing data are not compatible. In addition, within provinces, information on the basic health status of the population is fragmentary, and individual patient records from hospital and physician visits are not centralized.

The newly established Canadian Institute for Health Information (CIHI) aims to provide a more integrated approach to national health information services. It intends to collect information required for establishing sound health policy, for managing the health system, and for increasing awareness of health determinants. Ongoing at all levels of government are efforts to document the health status of populations through surveys and to investigate ways of linking existing individual records on births, deaths, and medical and social services.

Frequent questions are how well the health care system delivers services and whether they can be delivered in a more cost-effective way. In the area of standard medical care, health services researchers have suggested that 40% of hospitalizations are inappropriate and that 20% to 40% of surgical operations are unnecessary or dangerous. There is growing concern that the introduction of expensive new technologies, often without proper evaluation of their full costs and benefits and without any withdrawal of the older technologies that they are replacing, is responsible for much of the rising cost of health care. Similarly, evidence is needed to show that the effects of health promotion interventions are proportionate to their cost.

Many people do argue that health can be attained more cost-effectively through health promotion and disease prevention. The Montreal Diet Dispensary efforts in promoting wellness among low-income pregnant women led to the conclusion that for only \$6 million a year a prenatal program offering nutrition counselling, food and vitamin supplements, home visits and agency referrals could be provided to all disadvantaged pregnant women in Quebec; at present, more than \$10 million is spent annually on hospital care alone for low birthweight babies during their first year.

Various attempts have been made to evaluate effective disease prevention interventions. The Task Force on the Canadian Periodic Health Examination has specified a standard approach to the development of evidence-based guidelines for specific clinical preventive interventions that traditionally comprised the routine annual checkup. This has expanded to other preventive measures whose effectiveness is evaluated through an examination of evidence from randomized controlled trials, case control studies, cohort studies and others. In 1994, the Task Force identified more than 30 preventive measures where evidence suggests that harm outweighs good; examples were electric toothbrushes paid for by individuals and electronic fetal heart monitoring paid for by provincial insurance plans.

Governments are working together and separately to collect information and apply it in their decisions about resource allocation. The Canadian Coordinating Office for Health Technology Assessment, established in 1989 by the federal, provincial and territorial ministers of health, operates a clearinghouse for health technology information and prepares reports for provincial or territorial governments. British Columbia is one of several provinces attempting to establish guidelines on the appropriate use of services such as cholesterol testing and ultrasound tests during pregnancy. In Saskatchewan, where efforts are underway to reduce the length of hospital stays, it has been estimated that it costs about \$11,000 a month to keep someone in hospital but less than \$2,000 a month to care for that person at home. To avoid duplication of regional services, the premiers of New Brunswick, Prince Edward Island and Nova Scotia are considering a single health care system for the Maritime region.

3. Alternative Ways of Delivering Health

Refocusing on the promotion of health rather than the treatment of illness, combined with a desire to contain costs, encouraged consideration of other ways of using health professionals and of organizing health services. Boundaries are shifting between physicians and providers of alternative therapy, such as chiropractors and naturopaths, and between physicians and others who play important educational roles, such as nurses, pharmacists and nutritionists. Pressure is being exerted to find new ways to deliver health outside institutional settings and within the communities.

In New Brunswick, the Extra-Mural Hospital (hospital without walls) provides hospital-type consultation together with nursing at home. Although this is designated as a substitute for a general health care facility, patients must pay for certain services, such as meals and homemakers. After 60 days of illness, cases are considered chronic and transferred to the care of public health units or the Victorian Order of Nurses, which offer more traditional home care programs.

In Ontario, the establishment of Comprehensive Health Organizations (CHO) is in its initial stages. CHOs are non-profit corporations responsible to a community board comprising CHO members, key providers, and community representatives. CHO members agree to receive their health services from the organization's providers, who include physicians and other health professionals; in turn, the funding is provided on a per capita basis. While illness and injury are treated, there is a more comprehensive approach to health, including illness prevention and health promotion.

Quebec's *Centres locaux de services communautaires* (CLSCs) were established as part of a major reform of the health system in the early 1970s. They were publicly financed and staffed with teams of doctors, nurses, social workers and community development workers to provide the primary point of entry to social and health care. They are intended to be reflective of, and contributors to, the community. Lay people serve on the board of directors to facilitate consumer input into health policy development.

The Victoria Health Project in 1988 brought together three major health players in a new partnership. The British Columbia Ministry of Health, the Capital Regional District, and the Greater Victoria Hospital Society worked together to redesign and redirect the management of the community's health to shift the focus from hospital and medical matters to community participation. The initial target group was the frail elderly, a group identified as taking up a disproportionate share of the health care budget. Projects included clinical programs to provide alternatives to hospitalization; support programs for informal caregivers; and wellness centres focusing on prevention as well as treatment.

The use of health professionals other than physicians has been the focus of several efforts. In Newfoundland, a project sponsored by the World Health Organization focused on ways in which nurses can improve the health status of the local population through health promotion,

disease prevention and community participation, while at the same time reducing the costs for the health care system. In attempting to meet the health needs of native communities, the Canadian Public Health Association and Employment and Immigration Canada in 1993 proceeded with a project aimed at training and recruiting aboriginal public health workers.

Midwifery has been legalized in several provinces and plans to insure it under the provincial health plans have been announced in others. In Ontario, practising midwives can be certified, while aspiring ones can earn degrees at several schools in the province. Quebec in 1993 agreed to fund a pilot project that would pay accredited midwives to work out of an established hospital birthing centre. The cost for a midwife-assisted birth was estimated to be 60% of that for a birth with a physician presiding.

4. Identification of Societal Values

A health system that reflects the values and assumptions of Canadians will, in turn, shape them through decisions on delivery of health care. One challenge is to ensure that decisions affecting the health status and the health care of Canadians are based on a clearly understood set of principles and values. While some participants believe that the principles outlined in the *Canada Health Act* are the clearest statement of Canadian values about health care, not all agree.

Some efforts have been made at both the federal and the provincial levels to identify values to guide health policy decisions. This has most often been done through the study of Canadian views on particular issues. For example, over more than three years, the federal Royal Commission on New Reproductive Technologies examined the ethical as well as the social, medical, legal and economic implications of the reproductive technologies dealing with human conception and prenatal diagnosis. In looking at the impact of these on women, children and society as a whole, the Commission took the view that the values and attitudes of Canadians are important in helping to decide on what boundaries to place on the technologies. The deliberations and published report of the Commission were a public acknowledgement that technological innovations in health care, as in other areas, have created both social benefits and social costs, many of these just beginning to be recognized.

The Royal Commission on New Reproductive Technologies argued for a long list of principles to be considered and applied in this and other areas of health policy that go beyond a

doctor and patient relationship. It identified eight principles that should guide related policy decisions, including: individual autonomy, equality, respect for human life and dignity, protection of the vulnerable, non-commercialization of reproduction, appropriate use of resources, accountability, and balancing individual and collective interests.

The Royal Commission studied only those developments in science and medicine that give society the ability to create life and to improve life; however, other changes related to the ability to sustain life and to prolong life have also appeared. In Canada, as in many parts of the world, it is now accepted as routine that human infertility can be bypassed, genetic defects detected, organs transplanted, and individuals kept alive. Questions about the short-term and long-term positive or negative impact of such practices on individuals, their families and their communities are now being asked more often.

As biological, social and medical research has developed, numerous ethical questions have arisen, which affect all stages of human life. In relation to the beginning of life are issues of conception, embryo and fetal tissue use, abortion, prenatal diagnosis, genetic counselling and screening, and fetal therapy; at the end of life are issues such as care of the dying, termination of treatment, and assisted suicide. In the middle stages of life, topics such as organ transplantation, use of artificial organs, and contract motherhood or surrogacy are raised.

The value that Canadians place on each of these stages of life will ultimately affect the allocation of resources. Like other components of any health system, cost and values are interconnected; a country will probably afford what it values. This statement has particular significance at a time when the current publicly funded and publicly operated health care system is being criticized by those who argue that a private system would save money by making consumers more aware of real costs. Canadians already spend millions of dollars on health services not covered by medicare such as ambulances, drugs, physiotherapists, and dental work; such private payments in 1993 amounted to about 28% of total health expenditures in Canada.

Canadians' values need to be clearly identified and linked to any future health framework. While individual values are important, the effect of the health care system on families and communities must be understood. In Ontario, the recognition that aboriginal people share a holistic view of health, encompassing the physical, emotional, spiritual and cultural aspects of life, led to the development in 1994 of an aboriginal health policy. The policy acknowledges that

individuals can be empowered to direct their own health, but stressed the interdependency of individuals, families and communities and their responsibilities to each other.

5. Conclusion

Health policy development in Canada faces many challenges, of which one of the most significant is defining health and designing the means of achieving it. There is clear recognition that we need to move from a system focused predominately on health care to one more oriented to improved health status. To accomplish this, Canadians must identify those aspects of their society that they value the most; examine carefully what approaches will provide the best results; and support any shifting of resources deemed necessary to move in the direction of greater health for all. Many players will be involved: governments, physicians, hospital administrators, insurance companies and, ultimately, individual Canadians.

PARLIAMENTARY ACTION

The *Constitution Act, 1867* granted legislative authority over quarantine and the establishment and maintenance of marine hospitals to the federal government and the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions to the provinces.

The *Hospital Insurance and Diagnostic Services Act, 1957* provided conditional grants from the federal government to the provinces for the development of a national hospital insurance program. The plans were to be universally available to provincial residents, portable, and publicly administered. In addition, they were to ensure that adequate hospital standards and complete records and accounts were maintained.

The *Medical Care Act, 1966* established the basis for national insurance to cover medical services provided outside hospitals.

The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977* changed the cost-shared conditional funding arrangements for health insurance and

replaced them with block funding involving tax transfers and cash payments tied to the GNP. The previous legislation relating to hospital insurance and to medical care insurance was repealed.

The *Canada Health Act, 1984* established criteria and conditions that had to be met before full payment could be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law. The five criteria were comprehensiveness, universality, portability, public administration and accessibility.

The *Budget Implementation Act, 1996* set out new criteria for transfers to the provinces. The aim is to give the provinces more discretion over how funds are divided among health, post-secondary education, and social assistance.

CHRONOLOGY

- 1867 - The *British North America Act*, now the *Constitution Act, 1867*, contained few specifics about health.
- 1948 - The Health Grants Program offering federal cost-shared financial support provided the first stage in the development of a national health insurance plan. The prime objectives of the program were the development of surveys to assist provinces in understanding their health service needs, the establishment of services for training professional health workers, for helping crippled children, for fighting tuberculosis, cancer, venereal disease and mental illness, and the construction of hospitals.
- 1957 - National hospital insurance was established through the *Hospital Insurance and Diagnostic Services Act*.
- 1964 - The Royal Commission on Health Services under Emmett Hall pressed for a national health service that was universal, comprehensive, accessible, portable and publicly administered.
- 1966 - Federal funding for insured medical services was provided under the *Medical Care Act*.
- 1974 - Marc Lalonde, Minister of National Health and Welfare, published *A New Perspective on the Health of Canadians: A Working Document*.

1977 - The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* made it a condition of federal payments that the provincial plan would satisfy certain criteria.

1980 - Emmett Hall released the report of the Health Services Review '79, called *Canada's National-Provincial Health Program for the 1980s*. Extra-billing by physicians and hospital user fees were seen as endangering the principle of reasonable access to health care.

1981 - A House of Commons Task Force on Federal-Provincial Fiscal Arrangements concurred that extra-billing and user fees were detrimental. It concluded that federal funding for health care was adequate.

1984 - The *Canada Health Act* consolidated previous federal legislation and strengthened the federal commitment to the principles of universality, accessibility, portability, comprehensiveness and public administration.

1986 - Jake Epp, Minister for National Health and Welfare, published *Achieving Health for All: A Framework for Health Promotion*.

1990 - The Senate Standing Committee on Social Affairs, Science and Technology tabled its report *Accessibility to Hospital Services - Is There a Crisis?* It concluded that inefficiencies in acute-care hospitals could be and were being addressed through innovative administrative responses to recognized problems.

1991 - The House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women tabled its report *The Health Care System in Canada and Its Funding: No Easy Solutions*. The report concluded that increased spending on the existing system would not solve its problems. Instead, more cost-effective and appropriate distribution of human and other resources was needed.

1994 - Diane Marleau, Minister of Health, announced the nomination of 22 Canadians as members of the National Forum on Health. The Forum has a four-year mandate and a total budget of \$12 million to develop a new vision for Canada's health system. Four working groups will explore the major health-related themes: determinants, evidence-based decision making, societal values, and the balancing of resources. The National Forum on Health is now expected to report in early 1997.

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ACCO CANADA INC.
WILLODALE, ONTARIO

* INDICATES
75% RECYCLED
25% POST-
CONSUMER FIBRE



*SIGNIFIE 75 %
FIBRES RECYCLÉES,
25 % DÉCHETS DE
CONSOMMATION

BALANCE OF PRODUCTS
25% RECYCLED

AUTRES PRODUITS:
25 % FIBRES RECYCLÉES



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